

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10629

CERTIFICATE OF DEATH

03001201
Reg. Dist. No.

1. PLACE OF DEATH:

County Bert
City or town Worton and Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Chesapeake County Bert
City or town Worton and Rural Coleman
(If outside city or town limits, write RURAL and give nearest town)
Street No. Colemans
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Earnest Eugene Horsey

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) nov 11 1944
8. AGE: Years 4 Months 14 Days 14 If less than one day
..... hrs. min.

9. Birthplace Worton and Rural
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name aldrich & Horsey

13. Birthplace Worton and Rural

14. Maiden name Irene Shavers

15. Birthplace Worton

16. Informant aldrich & Horsey

Address Worton and Rural

17. Burial Burial Date thereof Mar 26/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Colemans Worton and

Location Colemans Worton and

18. Funeral director J.R. Fellows

Address Still Pond Md

19. March 26 1945 Registrar William Clark

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 25 1945 at 7:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from mar 22 1945 to mar 25th 1945
and that I last saw him alive on mar 25th 1945

Immediate cause of death Bronchitis DURATION 4 days

Due to

Due to malnutrition

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE L. P. Atwell M. D. or other

Address Still Pond Date signed 3/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 445

RECEIVED

APR 6 1945

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 467

CERTIFICATE OF DEATH

Reg. Dist. No. 03002 200

1. PLACE OF DEATH:

County KentCity or town Sassafras Ind.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6.8 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County KentCity or town Sassafras
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Elmer E. Ernest

3. (b) Social Security Number

4. Sex female5. Color or race White6. (a) Single, married, widowed, or divorced widow6. (b) Name of husband John F. Ernest7. Birth date of deceased (mo., day, yr.) April 23rd 1862

6. (c) If alive, give age _____ years

8. AGE: 82 Years _____ Months _____ Days _____
If less than 000 day _____ hrs. _____ min.9. Birthplace Del
(Town, county, and state)10. Usual occupation House work

11. Industry or business

12. Name Andrew C. Reynolds13. Birthplace Del14. Maiden name Sarah Cheffins15. Birthplace Del16. Informant Douglas ErnestAddress Middletown Delaware17. Burial Date thereof 3/24/45
(Burial, cremation, or other disposal) (month) (day) (year)Cemetery or location Sassafras CemeteryLocation Sassafras Ind.18. Funeral director Robert DanielsAddress Townsend Del.19. Mar. 24 - 19 45 Wesley Brice
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 20th 19 45 at 8:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 14 19 44 to March 20/45
and that I last saw him alive on March 20 19 45Immediate cause of death Carcinoma Gall Bladder
(Lymphoma since Nov 14/44)

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Walter R. Lee M.D.

M. D. or other

Address Middletown Del. Date signed _____

RECEIVED

APR 6 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1142

03903

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH:

County Kent
 City or town Jones Farm, Rock Hall R.R. Ind.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 months
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Rock Hall R.R. Ind.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If votoran, name war no

3. (a) FULL NAME

Clarence Van Court Jones
 4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Single

3. (b) Social Security Number

186-05-2143

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945, at 80 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19____, to 19____

and that I last saw h_____ alive on 19____

Immediate cause of death

Suicide

DURATION

Period of Mental Depression 6 yrs
Dep. that - suicidal
left chest over heart.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE

Frank W. Smith Deputy Medical
Chestertown, Md. M. D. 3/3/45
 Address _____ Date signed _____

6.(b) Name of husband or wife

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) December 8, 1891

8. AGE: Years 53 Months 2 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Kent Co. Ind.

(Town, county, and state)

10. Usual occupation Farmer11. Industry or business Motorway P.R.F.12. Name Richard Sterling Jones13. Birthplace Kent Co. Ind.14. Maiden name Harriett Ruggold15. Birthplace Kent Co. Ind.16. Informant Mrs. Beale JonesAddress Rock Hall Ind.17. Burial Date thereof MAR. 5, 1945

(Burial, cremation, or removal. Which?) _____ (month) (day) (year)

Cemetery or crematory St. Paul Cen.Location near Chestertown, Md.18. Funeral director J. Willis WellsAddress Chestertown, Md.19. Mar 5 1945 F. O. Smith

(Date rec'd by registrar) _____ Registrar

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK—Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF VITAL STATISTICS

STATE OF NEW YORK

DEPARTMENT OF HEALTH

OFFICE OF VITAL STATISTICS

STATE OF NEW YORK

DEPARTMENT OF HEALTH

RECEIVED

APR 3 1945

BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

03004

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH:

County Heart Rock HillCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 weeksHospital, institution, or street address where death occurred: —How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County —City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1708 Eldonmont St
(If rural, give LOCATION)2.(a) If veteran, name war —

3. (a) FULL NAME

Mary Frank Peewer

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced widowed6.(b) Name of husband or wife Edmund Peewer7. Birth date of deceased (mo., day, year) November 24 - 1859 6.(c) If alive, give age — years8. AGE: Years 85 Months 1 Days 10 If less than one day — hrs. — min.9. Birthplace Baltimore
(Town, county, and state)10. Usual occupation Housewife11. Industry or business —12. Name Edmund Peewer13. Birthplace Germany14. Maiden name Frank15. Birthplace Germany16. Informant Mr. Mat AlexanderAddress Rock Hall Md17. (Burial, cremation, or removal. Which?) Burial Date thereof March 6 - 1945
(month) (day) (year)Cemetery or crematory Baltimore Hebrew Cong.Location Belair Road18. Funeral director David Sord KeenAddress 1903 Eulaw Place Baltimore19. March 3 1945 S. Elwood Brinson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945 at 5:45 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 21 1945 to Feb. 28 1945 and that I last saw her alive on Feb. 28 1945Immediate cause of death Heart Block DURATION 6 weeksDue to —Due to Chronic Myocarditis 5 yearsOther conditions Sudden

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Frank M. Smith M. D. or other —Address Chesterbrook Md Date signed 3/3/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 12 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03005

Reg. Dist. No. 902

1. PLACE OF DEATH:

County Kent
 City or town Chestertown Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

Crews Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Chestertown Md
(If outside city or town limits, write RURAL and give nearest town)Street No. Washington Ave
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Armin Karst Law

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed6.(b) Name of husband or wife Thomas Law7. Birth date of deceased (mo., day, yr.) August 8, 18538. AGE: Years 91 Months 7 Days 15 If less than one day hrs. min.9. Birthplace Syracuse New York
(Town, county, and state)10. Usual occupation house work

11. Industry or business

12. Name Samuel Hunt-13. Birthplace Albany N.Y.14. Maiden name Mary Peterson15. Birthplace Syracuse N.Y.16. Informant Miss Clara ThrelkAddress Chestertown17. Burial Date thereof Mar. 26, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Saint Paul's CemeteryLocation Near Chestertown, Md.18. Funeral director J. Willis WellsAddress Chestertown, Md.19. March 25, 1945 Clara S. Barnes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1945 at 10:15 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1939 to Mar 23 1945
and that I last saw her alive on March 23 1945

Immediate cause of death

Cardiovascular Disease

DURATION

6 yr

Due to

Due to Arteriosclerosis6 yr

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank W Smith
Chestertown Md M. D. or other
Address Date signed 3/23/45

RECEIVED

APR 3 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

CERTIFICATE OF DEATH

03006

Reg. Dist. No. 203

1. PLACE OF DEATH:

County... Kent

City or town... Rock Hall
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... about 40 years

Hospital, institution, or street address where death occurred:
-

How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Kent

City or town... Rock Hall
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles August Schuelz

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife... Rosestine Schuelz

7. Birth date of

deceased (mo., day, yr.)

March 15 1859

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

85

11

18

hrs.

min.

9. Birthplace...

Baltimore, Md.
(Town, county, and state)

10. Usual occupation...

none

11. Industry or business

FATHER

12. Name...

John Schuelz

13. Birthplace...

Germany

MOTHER

14. Maiden name...

Sironenberg

15. Birthplace...

Germany

16. Informant...

Hon. John Thompson

Address

Rock Hall, Md.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof...

MAR 6, 1945
(month) (day) (year)

Cemetery or crematory...

811 N. WOLFE ST.

Location

BALTIMORE, MD.

18. Funeral director...

J. Willis Wells

Address

Chestertown, Md.

19. 3/6

(Date rec'd by registrar)

19 45

S. Elwood Buzen

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... March 5 19 45, at about 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 4 19 45 to March 5 19 45

and that I last saw him alive on 3/3 19 45

Immediate cause of death...

old age

due to 10 - myocardial

Due to... infection of right iliac

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? ...
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work? ...

23. SIGNATURE...

Robert A. Burgard

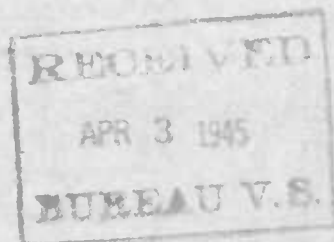
M. D. or other

Address...

Rock Hall, Md.

Date signed 3/10/45

811 N Wolf
Wolf 2569



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

03007

atwell

Reg. Dist. No. 201

FILM G 94 MAY 11 1945

1. PLACE OF DEATH:

County Stent
City or town Still Pond md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Stent
City or town Still Pond md
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Mattie Halley

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Haller Halley
7. Birth date of deceased (mo., day, yr.) Sept 10 - 1882 8. (c) If alive, give age _____ years
8. AGE: Years 62 Months 63 Days 5 If less than one day 21 hrs. _____ min.

9. Birthplace Still Pond md
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business _____
12. Name Henry Woolford
13. Birthplace Cambridge md
14. Maiden name Mary Wilton
15. Birthplace Still Pond md

16. Informant Perry anderson
Address Still Pond md
17. Burial Date thereof Apr 14/45
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Mt Zion
Location Still Pond md
18. Funeral director B R T Elbours
Address Still Pond md
19. April 4 19 45 J Mcleach
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 31 19 45 at 3 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 18th 1945 to Mar 31st 1945
and that I last saw her alive on Mar 31st 19 45

Immediate cause of death Uterine Prolaps
Wandering
DURATION
Due to _____
Due to _____
Other conditions Cancer of Liver 6 months
(Include pregnancy within 8 months of death)

Major findings of operations _____
Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE L. P. Atwell M. D. or other
Address Still Pond Date signed 4-3-45

RECEIVED
APR 6 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03008

Reg. Dist. No. _____

1. PLACE OF DEATH:

County _____

City or town _____

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: _____

Stay in hospital or inst. (yrs., or mos., or days) _____

Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State _____

County _____

City or town _____

(If outside city or town limits, write RURAL NEAR and give town)

Ward No. _____

Street No. _____

(If rural give LOCATION) _____

2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Raymond G. Taylor

3. (b) Social Security Number

717-07-9147

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

B. (b) Name of husband or wife

Eleanor Taylor

7. Birth date of

deceased (mo., day, yr.)

June 30 1874

6(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

78

hrs.

min.

9. Birthplace

Stockton, Md.

(Town, county, and state)

10. Usual occupation

P.R.R. Station Agent

11. Industry or business

FATHER

12. Name

John Taylor

13. Birthplace

Md.

MOTHER

14. Maiden name

Sallie Jones

15. Birthplace

Md.

16. Informant

Mrs. Eleanor Taylor

Address

Millington, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Millington

Location

Millington, Md.

18. Funeral director

Edward F. Taylor

Address

Millington, Md.

19.

(Date rec'd by registrar)

2/27

M. Davis
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 23

1945, at 8 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 22

1945

to

March 23

1945

and that I last saw him alive on

March 22

1945

Immediate cause of death

Coronary Embolism

DURATION

Sudden

Due to

Due to

Phlebitis

1944

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. Davis

M. D. or other

Address

Millington, Md.

Date signed 2/27/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 6 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Pa*

03009

CERTIFICATE OF DEATH

Reg. Dist. No. *202*

1. PLACE OF DEATH:

County *Kent*
City or town *Chestertown*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Kent*
City or town *Chestertown*
(If outside city or town limits, write RURAL and give nearest town)Street No. *Mt. Vernon Ave.*
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Katherine Rebecca White

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Widowed*6.(b) Name of husband or wife *Thomas Henry White*

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) *Sept. 9, 1862*8. AGE: Years *82* Months *6* Days *14* if less than one day _____ hrs. _____ min.9. Birthplace *Queen Anne Co. Md.*
(Town, county, and state)10. Usual occupation *Housewife*

11. Industry or business

12. Name *John M. Toulson*13. Birthplace *Md.*14. Maiden name *Sarah Elizabeth Murdock*15. Birthplace *Md.*16. Informant *Mrs. Phillip Sewell*Address *Chestertown, Md. (daughter)*17. *Burial* Date thereof *Mar. 26, 1945*
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory *Chester*Location *Chestertown, Md.*18. Funeral director *J. Willis Wells*Address *Chestertown, Md.*19. *March 25, 1945* *Clara L. Barnes*
(Date rec'd by registrar) Registrar

March MEDICAL CERTIFICATION

20. DATE OF DEATH *March 23, 1945* at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 14, 1945 to *March 23, 1945*
and that I last saw her alive on *March 20, 1945*Immediate cause of death *Aortic insufficiency* DURATION *6 months*

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please enter the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE *H. B. Simmons*M. D. *Simmons*Address *Chestertown, Md.* Date signed *3-24-45*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

CERTIFICATE OF DEATH

Reg. Dist. No.

03010

Price

1. PLACE OF DEATH:

County Kent
 City or town Galena Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Galena and Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. near Galena
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

William Nealey Webb

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Katie A Webb
 7. Birth date of deceased (mo., day, yr.) Feb 5 1863 6. (c) If alive, give age 87 years
 8. AGE: Years 87 Months 1 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Kent Co Maryland
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business Farming
 12. Name Joseph J Webb
 13. Birthplace Maryland
 14. Maiden name Wylie T Simpson
 15. Birthplace Allegheny

16. Informant Katie A Webb
 Address Galena and Rural
Bural
 Date thereof Mar 24/95
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Shrewsbury
 Location Near Kennedyville and
 18. Funeral director B. V. T. Tollows
 Address Still Pond and

19. Mar. 23 1945 E. J. Muefort
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 22 1945 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1945 to March 22 1945
 and that I last saw him alive on March 21 1945

Immediate cause of death Murder

DURATION

3 daysDue to Ch. Intestinal InflectionAcute formDue to Ch. MyocarditisAcute form

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wm. B. Price

M. D. or other

Address Millington MdDate signed 3/24/45

CERTIFICATE OF DEATH

RECEIVED
APR 6 1945
BUREAU V.S.